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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00001 00001

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: East Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: C. — Last: Abbott

4. DATE OF DEATH: Month: January — Day: 13, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 15, 1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Judge

10b. KIND OF BUSINESS OR INDUSTRY: Orphans Court

11. BIRTHPLACE (County & State, or foreign country): Galston, Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Abbott

14. MOTHER'S MAIDEN NAME: Lilias Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss. Lilias Abbott "Daughter" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
420.1
DUE TO (b) Arteriosclerosis & coronary insufficiency — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 1956 to Jan. 13 1962, that (I) (we) last saw the deceased alive on Jan. 12 1962, and that death occured at 5 a M, from the causes and on the date stated above.

22a. SIGNATURE: L. R. Miles MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1.15.62

22c. PHYSICIAN'S NAME (Type): L. R. MILES, JR. M.D.

22d. ADDRESS: Lonaconing Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/15/62

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

23d. LOCATION (City, town or county) (State): Moscow, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: JAN 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... obtained by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00002 **CERTIFICATE OF DEATH** 00002

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 512 CUMBERLAND STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GRACE Middle: C Last: ANKENEY

4. DATE OF DEATH: Month: JANUARY Day: 3 Year: 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JULY 6, 1876

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: BENJAMIN F. CHARLES

14. MOTHER'S MAIDEN NAME: MARY E. GARDNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

422

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular disease 4 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Macrocytic anemia (Pernicious) Controlled

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1939, 19 to A.M. 3 Jan., 19 62, that (I) (we) last saw the deceased alive on 2 Jan. 1962 and that death occured at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3 Jan. 62

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/4/62

23c. NAME OF CEMETERY OR CREMATORY: St Pauls Cem.

23d. LOCATION (City, town or county) (State): Clear Spring Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Louis Stein Inc Cumb. Md.

25a. REC'D BY REGISTRAR DATE: JAN 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00003 Item 14 Film G305 1/29/62 iwk 00003

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ECKHART
c. LENGTH OF STAY IN 1b: 49 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ECKHART
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle Last ARNONE
4. DATE OF DEATH: Month Jan Day 19 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 20TH, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET.-MINER
10b. KIND OF BUSINESS OR INDUSTRY: COAL MINING
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: JOSEPH ARNONE
14. MOTHER'S MAIDEN NAME: Sarafina Filcatti
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ENORDO ARNONE, Address 72 ARMSTRONG ST., F'BG. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of Skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Laceration of Brain
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9766

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self in Rt Ear with 22 Revolver
20c. TIME OF INJURY: Hour 11:30 a. m. p. m. Month, Day, Year Jan 19 1962
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Yard
20f. (City or town) Eckhart (County) Allegany (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W D McLane M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W D McLane MD Asst
DATE SIGNED: Jan 19 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-22-62
22c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY
22d. LOCATION (City, town, or county) (State): FROSTBURG, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst
ADDRESS: FROSTBURG, MD.
24a. REC'D BY REGISTRAR: DATE JAN 23 '62
24b. REGISTRAR'S SIGNATURE: Clifford S. Frame

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00004

CERTIFICATE OF DEATH

Reg. Dist. No. 00004

1. PLACE OF DEATH
a. COUNTY: Alleghany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8 Crescent St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Alleghany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 8 Crescent
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard; Middle Henry; Last Atkinson

4. DATE OF DEATH: Month January; Day 15; Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 14, 1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry W. Atkinson

14. MOTHER'S MAIDEN NAME: Mary E. Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 214-05-7643

17. INFORMANT: Mrs Beverly Atkinson — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO (b) Partial paralysis legs, bladder bowel — 9 years
DUE TO (c) Extra Dural Spinal Sarcoma L3-L5 — 9 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1962

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25, 1954, to Jan 15, 1962, that I last saw the deceased alive on Jan 15, 1962, and that death occurred at 4 05 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Rhett Rathbone M.D. — ADDRESS (Street, city or town, state): 122 S. Centre Street — DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. R. Rhett Rathbone — Cumberland, Maryland

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

22b. DATE THEREOF: 1-18-62

22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F.

22d. LOCATION (City, town, or county) (State): Elk Garden W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Kyle Pritts Sr. — ADDRESS: Kitzmiller, Md.

24a. REC'D BY REGISTRAR DATE: JAN 22 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00005 **CERTIFICATE OF DEATH** 00005

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 10/17/1956
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice Middle: R. Last: Barrett
4. DATE OF DEATH: Month: January Day: 29, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/31/1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Confectionery
11. BIRTHPLACE (County & State, or foreign country): Mt. Savage, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: James E. Barrett
14. MOTHER'S MAIDEN NAME: Mary V. Luckey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, Chr, degenerative
DUE TO (b) Arteriosclerosis & Hypertension
DUE TO (c) Cerebral Hemorrhage, left Hemiplegia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

434X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/17/56, 19..., to 1/29/62, 19..., that (I) (we) last saw the deceased alive on 1/29/62, 19..., and that death occured at @ 9:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Lee B. Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 1/29/62
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Feb 1-1962
23c. NAME OF CEMETERY OR CREMATORY: ST PATRICKS
23d. LOCATION (City, town or county) (State): MT. SAVAGE MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Durst ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE FEB 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00006 **CERTIFICATE OF DEATH** 00006

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gilmore, R-F-D 1 Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gilmore R-F-D 1 Frostburg
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: A. Last: Beeman
4. DATE OF DEATH: Month: 1 Day: 8 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/26/1895
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Garrett County
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Andrew Beeman
14. MOTHER'S MAIDEN NAME: Mary R. Green
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes, World War # 1
16. SOCIAL SECURITY NO.: 216-05-2965
17. INFORMANT: Mrs. Lulu Beeman, (WIFE) Address: Gilmore, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 6 mo
DUE TO (b): Bronchial Asthma — ?
DUE TO (c):

241X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 27, 1961, to Jan 8, 1962, that (I) (we) last saw the deceased alive on Dec 27, 1961, and that death occured at 10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Wm McLane M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 9 1962
22c. PHYSICIAN'S NAME (Type): W O McLANE MD
22d. ADDRESS: Frostburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/11/1962
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town or county) (State): Lonaconing, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: LONACONING, MD.
25a. REC'D BY REGISTRAR DATE: JAN 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00007 **CERTIFICATE OF DEATH** 00007

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 534 FORT AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JOHN Middle: E. Last: BENNETT

4. **DATE OF DEATH**: Month: JANUARY Day: 14, Year: 1962.

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 1, 1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN BENNETT
14. MOTHER'S MAIDEN NAME: ANN SOWERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

15 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January, 1961 to Jan 14, 1962, that (I) (we) last saw the deceased alive on January 14, 1962 and that death occured at 12:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schindler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/16/62
22c. PHYSICIAN'S NAME (Type): DR. BLANE M. SCHINDLER
22d. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan 17, 1962
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
23d. LOCATION (City, town or county) (State): Cumberland Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer
ADDRESS: Cumberland Md
25a. REC'D BY REGISTRAR DATE: JAN 19 '62
25b. REGISTRAR'S SIGNATURE: Corinne E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00008

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00008

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 300 Willowbrook Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Maryland 02
d. STREET ADDRESS: 300 Willowbrook Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Moses — Middle: Sylvester — Last: Bennett
4. DATE OF DEATH: Month: January — Day: 31 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/23/1917
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Kelly Sp. Tire Co.
11. BIRTHPLACE (State or foreign country): Reeses Mill, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Phillip Bennett
14. MOTHER'S MAIDEN NAME: Mary Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. II
16. SOCIAL SECURITY NO.: 217-10-5403
17. INFORMANT: Woodrow Bennett, Address: Golden Lane, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GUNSHOT OF CHEST — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
9817
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 31, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. R9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 3, 1962
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Near Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John J. Hofer — ADDRESS: Cumberland Md.
24a. REC'D BY REGISTRAR: DATE FEB 6 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Hirons

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00009 **CERTIFICATE OF DEATH** 00009

M

62

I

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 59 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 147 BEDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IVY Middle: M. Last: BIBLE
4. DATE OF DEATH: Month: JAN. Day: 15 Year: 19 62
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 5, 1880
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: WILL BROOKS (DECEASED)
14. MOTHER'S MAIDEN NAME: ~~ANN~~ Rebecca, A. Flagg (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-05-6128
17. INFORMANT: PATIENTS CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive thrombophlebitis of vena cava — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) Generalized atherosclerosis — 59 days
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 50.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/4, 1962 to 1/15, 1962, that (I) (we) last saw the deceased alive on 1/14 1962, and that death occured at 2:17 A.M. from the causes and on the date stated above.

22a. SIGNATURE: S Weisman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/15/62
22c. PHYSICIAN'S NAME (Type): SAVILLE G. WEISMAN, M.D.
22d. ADDRESS: GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/17/62
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Park
23d. LOCATION (City, town or county) (State): Cumberland, Md
24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: JAN 18 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00010 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00010

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rt. # 1 Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Bowmans Addition

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. # 1 Cumberland,
d. STREET ADDRESS: Bowmans Addition
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adam — Middle: Henry — Last: Bloss
4. DATE OF DEATH: Month: Jan. — Day: 27, — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 16, 1880
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Brakeman
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.
11. BIRTHPLACE (State or foreign country): North Branch, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Stephan A. Bloss
14. MOTHER'S MAIDEN NAME: Elizabeth Knippenberg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give wer or dates of service): ----
16. SOCIAL SECURITY NO.: 705-07-9747A
17. INFORMANT: Mrs. Arzeltha M. Bloss — Address: Rt. # 1 Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b): CORONARY SCLEROSIS — ----
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): R D 9 Cumberland,
DATE SIGNED: January 28, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/30/62
22c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
22d. LOCATION (City, town, or country) (State): Cumberland, Md.
23. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR: DATE JAN 31 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00011 **CERTIFICATE OF DEATH** 00011

Item 1b Film G305 1/18/62 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4) 15M 7/61

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): MT. SAVAGE/ Cumberland
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD.
b. COUNTY: ALLEGANY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS: Old Row
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALMA Middle: N Last: BRAILER

4. DATE OF DEATH: Month: JAN Day: 10 Year: 1962

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/22/09
9. AGE (in years last birthday): 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cumb. Blouse Factory
10b. KIND OF BUSINESS OR INDUSTRY: Blouses
11. BIRTHPLACE (County & State, or foreign country): Zihlman Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELIAS WILLIAMS
14. MOTHER'S MAIDEN NAME: Margaret Koontz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Infarction, LLL — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b) Pulmonary Embolus — 1 week
DUE TO (c) Myocardial Infarction - Coronary Occlusion - Arteriosclerotic Heart Disease — 15 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 2, 1962 to Jan 10, 1962, that (I) (we) last saw the deceased alive on Jan 10 1962, and that death occured at 1:65 AM from the causes and on the date stated above.

22a. SIGNATURE: H Weisman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/11/62
22c. PHYSICIAN'S NAME (Type): DR. WEISMAN
22d. ADDRESS: 59 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/13/62
23c. NAME OF CEMETERY OR CREMATORY: St Patricks Cem
23d. LOCATION (City, town or county) (State): Mt Savage Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: Cumberland Md
25a. REC'D BY REGISTRAR DATE: JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur J. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00012 00012

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT#1, BOX503 BOWMAN'S ADD.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle A. Last BRIDGES

4. DATE OF DEATH: Month JAN. Day 23 Year 1962

5. SEX: male
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/21/91
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): IRONWORKER
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM BRIDGES
14. MOTHER'S MAIDEN NAME: MARGARET BARTELOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 275 07 6701
17. INFORMANT: CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
331X	IMMEDIATE CAUSE (a) Uraemia	10 days
	DUE TO (b) Massive cerebral haemorrhage	2 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (c) Arteriosclerosis	5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 15 1962 to Jan 25, 1962 that (I) (we) last saw the deceased alive on Jan 22 1962, and that death occured at 2:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clay R. Durrett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/24/62
22c. PHYSICIAN'S NAME (Type): DR. DURRETT
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 26, 1962
23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK
23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE JAN 26 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

Items 18-20 Film 305 I-19-62 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00013 Item 8 Film G305 1/11/62 jwk 00013

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02 1
d. STREET ADDRESS: 501 OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle A Last BRINKER

4. DATE OF DEATH: Month JAN Day 4 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 7-23-1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (County & State, or foreign country): MARYLAND Cumberland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Mathias Brinker
14. MOTHER'S MAIDEN NAME: Louise Ruppenkamp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wars or dates of service):
16. SOCIAL SECURITY NO.: 233-50-8347
17. INFORMANT: PT'S CHART Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b): Myocarditis & Decompensation — 3 mos
DUE TO (c): [illegible]

422.2 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fractured left hip - 9 days

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (If either, notify Medical Examiner): Natural causes
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell from chair at home
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: Dec. 23 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 26, 1961 to Jan 4, 1962 that (I) (we) last saw the deceased alive on Jan 4 1962 and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/5/62
22c. PHYSICIAN'S NAME (Type): Clay E. DR. DURRETT
22d. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: I-8-62
23c. NAME OF CEMETERY OR CREMATORY: St Patrick Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00014 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00014

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Westernport
c. LENGTH OF STAY IN 1b: 7 Months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D. 1, 2 Mi. N. Westernport

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-Westernport
d. STREET ADDRESS: R.D. 1, 2 Mi. N. Westernport
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Steven; Middle: Joe; Last: Broadwater
4. DATE OF DEATH: Month: Jan.; Day: 26; Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1961
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: 7; Days: 26 IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Garland D. Broadwater
14. MOTHER'S MAIDEN NAME: Shirley Ann Mongold
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Garland D. Broadwater-R.D.1 Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 4-5 Min
DUE TO (b) Aspiration of Stomach Contents — ------
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

500 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute tracheobronchitis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: W D McLane M.D.
EXAMINER'S NAME (Type): W D McLane MD 024
DATE SIGNED: January 25, 1962
Address (Street, city, town, or county): Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/28/62
22c. NAME OF CEMETERY OR CREMATORY: Bloomington ~~Lehmansville Cem.~~
22d. LOCATION (City, town, or country): Bloomington ~~Lehmansville~~ (State): Md. ~~W. Va.~~

23. FUNERAL DIRECTOR: E L Burel
ADDRESS: Westernport, Md
24a. REC'D BY REGISTRAR: DATE JAN 29 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

2060183076

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00015 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00015

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rt. 1 Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Bowmans Addition

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 1 Cumberland,
d. STREET ADDRESS: Bowmans Addition
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First THOMAS Middle EDWARD Last BROWN

4. DATE OF DEATH: Month Jan. Day 2, Year 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 30, 1904
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman Machinist
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas E. Brown
14. MOTHER'S MAIDEN NAME: Grace Hansel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No,
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Address: Mrs. John Miltenberger Ridgeley, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b) CORONARY SCLEROSIS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 1/2/62
EXAMINER'S NAME (Type): Benedict Skitarelic M.D,
Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/4/62
22c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Mem. Gardens
22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR: DATE JAN 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00016 00016

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 24 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 418 PACA STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TILLIE — Middle — Last BROWN
4. DATE OF DEATH: Month JANUARY — Day 30, — Year 1962
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 12, 1892
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ANTHONY KNOCHE
14. MOTHER'S MAIDEN NAME: MARGARET METZGER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, — (If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — 2 days
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) Cumberland (County) Alleg (State) Md

21. **I certify** that (I) (this hospital) attended the deceased from Jan 6, 1962 to 1/30/62, 19..... that (I) (we) last saw the deceased alive on 1/29/62 19....., and that death occured at 12:55 AM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/31/62
22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22d. ADDRESS: 122 SO. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/1/62
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. Wayne George Cumberland, Md.
25a. REG'D BY REGISTRAR — DATE
25b. REGISTRAR'S SIGNATURE: Clarence E. Frame

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00017 **CERTIFICATE OF DEATH** 00017

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 710 Maryland Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 710 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances Middle: Elizabeth Last: Butler

4. DATE OF DEATH: Month: January Day: 8 Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: December 20, 1875
9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Haldeman
14. MOTHER'S MAIDEN NAME: Mary Farrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Mary M. Wright — Address: 710 Maryland Avenue, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, chr., degenerative
DUE TO (b) Arteriosclerosis, general
DUE TO (c) Senility

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1940, 19, to 1-8, 1962 that (I) (we) last saw the deceased alive on 1-8 1962, and that death occured at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D.
22b. DATE SIGNED: 1-9-62
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): L. B. Mathews M.D.
22d. ADDRESS: 49 Green St, Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/11/62
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City, town or county) (State): Cumberland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland Maryland
25a. REC'D BY REGISTRAR DATE JAN 11 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00018 **CERTIFICATE OF DEATH** 00018

Item 9 Film 8305 1/29/62 iwk

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 213 W. SECOND ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PHILLIP — Middle: — Last: CALVETTA

4. DATE OF DEATH: Month: JAN. — Day: 17 — Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JUNE 17, 1887

9. AGE (In years last birthday): 73/74 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED*RAILROAD

10b. KIND OF BUSINESS OR INDUSTRY: Machinist

11. BIRTHPLACE (County & State, or foreign country): ITALY - ROME

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 215-12-2176

17. INFORMANT: PATIENTS CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Myocarditis & Decompensation — 3 mos
DUE TO (c): Arteriosclerosis — 5 yrs

293X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1962 to Jan. 17, 1962, that (I) (we) last saw the deceased alive on Jan 16, 1962, and that death occured at 8:40AM from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/17/62

22c. PHYSICIAN'S NAME (Type): Clay E. Durrett, M.D.

22d. ADDRESS: 236 Virginia Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan.20,1962

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli, Cumberland, Md.

ADDRESS:

25a. REC'D BY REGISTRAR: DATE JAN 24 '62

25b. REGISTRAR'S SIGNATURE: Carlton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00019

CERTIFICATE OF DEATH

00019

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1/6/1962
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 502 Washington Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter; Middle: C.; Last: Capper

4. DATE OF DEATH: Month: January; Day: 21; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/5/1885
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Lawyer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles M. Capper
14. MOTHER'S MAIDEN NAME: Nancy Fletcher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive degenerative, Senile
DUE TO (b) Arterio-Sclerosis, Cerebral
DUE TO (c) deterioration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/6/1962, 19....., to 1/21/1962 19....., that (I) (we) last saw the deceased alive on 1/21/1962 19....., and that death occured at @ 11:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 1/22/62
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/24/62
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.
23d. LOCATION (City, town or county) (State): Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.
ADDRESS: Cumb. Md
25a. REC'D BY REGISTRAR DATE: JAN 24 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00020 00020

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN Ib: 1day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: ROUTE #1, BOX 370
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CLARENCE Middle R. Last CARTER

4. DATE OF DEATH: Month 1 Day 10 Year 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-22-97
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire Builder
10b. KIND OF BUSINESS OR INDUSTRY: Kelly-Springfield
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN CARTER
14. MOTHER'S MAIDEN NAME: Elizbeth Delaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-09-7347
17. INFORMANT: (Sister) Genevieve Lyons Address: Hoffman, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1hour
DUE TO (b) arteriosclerosis — 1year
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-3, 1961, to 1-10, 1962, that (I) (we) last saw the deceased alive on 1-10-1962, and that death occured at 8:24 PM, from the causes and on the date stated above.

22a. SIGNATURE: L. Brings M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L.BRINGS,M.D.
22d. ADDRESS: 57 GREENE ST. Cumberland Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-13-62
23c. NAME OF CEMETERY OR CREMATORY: St. Michaels
23d. LOCATION (City, town or county) (State): Frostburg, Maryland

FUNERAL DIRECTOR'S SIGNATURE: Pearl Mattingly
ADDRESS: Hafer Funeral Home 23 E. Main Frostburg, Md
25a. REC'D BY REGISTRAR DATE: JAN 16 '62
25b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00021

CERTIFICATE OF DEATH

00021

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ECKHART
c. LENGTH OF STAY IN 1b: LIFETIME
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ECKHART
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: M. — Last: CARTER

4. DATE OF DEATH: Month: JANUARY — Day: 2ND, — Year: 19 62

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 15TH, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. MAGISTRATE
10b. KIND OF BUSINESS OR INDUSTRY: POLICE COURT
11. BIRTHPLACE (County & State, or foreign country): ECKHART
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES CARTER
14. MOTHER'S MAIDEN NAME: HARRIET PORTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 217-14-4872
17. INFORMANT: MRS. ELIZA W. CARTER, ECKHART, MD. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 26, 1961, to Jan 2, 1962, that (I) (we) last saw the deceased alive on Jan 2, 1962, and that death occured at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. O. McLane — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 3 1962
22c. PHYSICIAN'S NAME (Type): W. O. McLANE, "
22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-5-1962
23c. NAME OF CEMETERY OR CREMATORY: PORTER CEMETERY
23d. LOCATION (City, town or county) (State): ECKHART, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: F. R. Durst — ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00022 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00022

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 27 UHL STREET

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 27 UHL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LEO Middle V. Last CHAMBERS
4. **DATE OF DEATH** Month JANUARY Day 26 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 28, 1889
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN B. CHAMBERS
14. MOTHER'S MAIDEN NAME: MARY B. McALLISTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): W.W.1
16. SOCIAL SECURITY NO.: 215-20-5306
17. **INFORMANT**: EUGENE CHAMBERS, Address 35 ALLEN AVENUE, WOODSTOWN, N. J.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b) CORONARY SCLEROSIS WITH THROMBOSIS
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: W O McLane M.D.
EXAMINER'S NAME (Type): W O McLane MD and
Address (Street, city, town, or county): Frostburg Md
DATE SIGNED: 1-27-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-29-62
22c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY
22d. LOCATION (City, town, or country): FROSTBURG, (State) MD.

23. FUNERAL DIRECTOR: J. R. Durst ADDRESS: FROSTBURG, MD.
24a. REC'D BY REGISTRAR DATE JAN 29 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00023 **CERTIFICATE OF DEATH** 00023

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 606 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 606 Maryland Ave!
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: M.; Last: Charlton
4. DATE OF DEATH: Month: Jan.; Day: 25; Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 23, 1872
9. AGE (In years lost birthday): 89 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Moorefield, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John H. Boswell
14. MOTHER'S MAIDEN NAME: Anna Whetzel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. Jack Corbett, Cumberland, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b) Myocarditis & Decompensation — 1 yr
DUE TO (c) Arteriosclerosis — 5 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Mar 1961, to Jan 25 1962 that (I) (we) last saw the deceased alive on Jan 21 1962 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/26/62
22c. PHYSICIAN'S NAME (Type): Dr. Clay E. Durrett, M.D.
22d. ADDRESS: 236 Virginia Ave. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 28, 1962
23c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Moorefield, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE: JAN 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00024 00024

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 547 N, Centre St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Evelyn — Middle: Marie — Last: Clark
4. DATE OF DEATH — Month: January — Day: 21 — Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 29, 1896
9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Franklin, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John R. Sharretts
14. MOTHER'S MAIDEN NAME: Mary E. Howarth
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service):
17. INFORMANT — Address: Mrs. Albert May Cresaptown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Days

443X

DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE — -----

DUE TO (c) ARTERIOSCLEROSIS — *****--

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JANUARY 21, 1961
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): R 9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 24, 1962
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or country) (State): Cumberland, Maryland
23. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: 117 Frederick St. Cumb., Md.
24a. REC'D BY REGISTRAR: JAN 24 '62 — DATE
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00025 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00025

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 511 Dilley Street

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 511 Dilley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Ellen — Last: Clark
4. DATE OF DEATH: Month: January — Day: 14 — Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: January 16, 1889
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewrok
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Henry Petenbrink (Deceased)
14. MOTHER'S MAIDEN NAME: Mary Everline (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-14-7580
17. INFORMANT: Mrs. E. M. Horchler — Address: Route #3 Cumberland Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) UREMIA — MONTHS

422.1

DUE TO (b) CHRONIC GLOMERULARNEPHRITIS — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 14, 1962
Address (Street, city, town, or county): R 9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/17/62
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or country) (State): Cumberland Maryland
23. FUNERAL DIRECTOR: Ruth E. Silcox — ADDRESS: 404 Decatur Street Cumberland Maryland
24a. REC'D BY REGISTRAR — DATE: JAN 18 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00026 **CERTIFICATE OF DEATH** 00026

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL*** RIDGELEY 85X·3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First REBECCA — Middle J. — Last COLMER

4. DATE OF DEATH: Month JAN. — Day 23 — Year 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 4/6/1878
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): ACCIDENT - GARRETT CO. - MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM HUTZELL
14. MOTHER'S MAIDEN NAME: SARAH BURKHOLDER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Earl E. Colmer Address: Rt 1, Ridgeley, W.Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Cerebral Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
332X
DUE TO (b): Arteriosclerosis, General
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus — Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/22, 1962, to 1/23, 1962, that (I) (we) last saw the deceased alive on 1/23, 1962, and that death occured at 11 a.m., from the causes and on the date stated above.

22a. SIGNATURE: S. Weisman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/23/62
22c. PHYSICIAN'S NAME (Type): S.G. WEISMAN, M.D.
22d. ADDRESS: 59 Greene St Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-26-62
23c. NAME OF CEMETERY OR CREMATORY: SALISBURY I.O.O.F.
23d. LOCATION (City, town or county) (State): SALISBURY - SOMERSET CO. - PA.

24 FUNERAL DIRECTOR'S SIGNATURE: Stanley M Thomas — ADDRESS: Salisbury, Pa
25a. REC'D BY REGISTRAR — DATE: JAN 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Timmons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00027 Items 3 & 13 Film G307 2/19/62 iwk & 17 00027

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Little Orleans
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Little Orleans Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard; Middle: ~~Conrad~~; Last: Conrad
4. DATE OF DEATH: Month 1; Day 27; Year 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6.14 1938
9. AGE (In years last birthday): 23 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter
11. BIRTHPLACE (State or foreign country): Bedford County Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Theadore ~~Conrad~~ Conrad
14. MOTHER'S MAIDEN NAME: Gladys O, Neal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Norma M ~~Conrad~~ Conrad — Address: Little Orleans Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 10-15 Min.
835X
DUE TO (b) Compression of chest — "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Auto slipped off jack pinning victim underneath.
20c. TIME OF INJURY: Hour 5.00 ~~a.m.~~ p.m. Month, Day, Year: Jan 27 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — (City or town): Bolly Grove — (County): Allegany — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Jan. 27, 1962
EXAMINER'S NAME (Type)
Address (Street, city, town, or county): RD 9 Cumberland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2.1.62
22c. NAME OF CEMETERY OR ~~XXXXXXX~~: Pine Grove
22d. LOCATION (City, town, or county) (State): Monrow Township Bedford Pen.
23. FUNERAL DIRECTOR: Howard F. Stone — ADDRESS: Hancock Md
24a. REC'D BY REGISTRAR DATE: JAN 30 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Nunus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00028 Item 1d Film G305 1/18/62 mh 00028

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Died in car before being admitted to Miners Hospital.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: West Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: Daley
4. DATE OF DEATH: Month: January — Day: 11 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 23, 1881
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 216-05-5910
17. INFORMANT: Mrs. Isablle Winters "Daughter" — Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: mos.
DUE TO
(b) Arteriosclerotic CV disease class III — Years
DUE TO
(c) Diabetes Mellitus — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 19, 1956, to January 11 1962, that (I) (we) last saw the deceased alive on January 9 1962, and that death occured at 11:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. Miles M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-12-62
22c. PHYSICIAN'S NAME (Type): Leslie R. Miles, Jr., M.D.
22d. ADDRESS: Lonaconing, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/1/14
23c. NAME OF CEMETERY OR CREMATORY: St Marys Cemetery
23d. LOCATION (City, town or county) (State): Lonaconing, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn — ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR — DATE: JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Clarence S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00029 00029

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1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Westernport
c. LENGTH OF STAY IN 1b: 19yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1 Mi N.W. Westernport

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural-Westernport
d. STREET ADDRESS: 1 Mi. N.W. Westernport
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Catherine; Middle: ; Last: Davis

4. DATE OF DEATH: Month: Jan.; Day: 25; Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 4, 1873
9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Grant Ct. W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Schell
14. MOTHER'S MAIDEN NAME: Mary Cosner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clara Wilson — Address: Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of the large Bowel — INTERVAL BETWEEN ONSET AND DEATH: 3 years.
153.9
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December, 1958, to Jan 25, 1962, that (I) (we) last saw the deceased alive on 1-25, 1962, and that death occured at 10:30 pM, from the causes and on the date stated above.

22a. SIGNATURE: William W. Lesh M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): William W Lesh
22d. ADDRESS: Westernport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/28/62
23c. NAME OF CEMETERY OR CREMATORY: Lahmansville
23d. LOCATION (City, town or county) (State): Lahmansville W.Va.

24 FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE JAN 29 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Graves

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 [illegible] after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00030 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00030

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 633 Elm Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 633 Elm Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Austin — Last: Davis

4. DATE OF DEATH: Month: January — Day: 15 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/18/1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: City Street Dept

11. BIRTHPLACE (State or foreign country): Williams Road, Cumberland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jesse Davis

14. MOTHER'S MAIDEN NAME: Ella Jeffries

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): W.W. 1

16. SOCIAL SECURITY NO.: 220-10-2446

17. INFORMANT: Edna Schell Davis — Address: 633 Elm Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

420.1

DUE TO (b): CORONARY SCLEROSIS — -----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: January 16, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/18/62

22c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery

22d. LOCATION (City, town, or country): Cumberland — (State): Maryland

23. FUNERAL DIRECTOR: John J. Hafer — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR: DATE JAN 19 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00031 **CERTIFICATE OF DEATH** 00031

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN Ib: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLERSLIE, MARYLAND
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle E — Last DE VORE

4. DATE OF DEATH: Month JANUARY — Day 6 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: MAY 2, 1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: KELLY SPRINGFIELD TIRE CO.

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN DE VORE

14. MOTHER'S MAIDEN NAME: BARBARA WITT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes give war or dates of service)

17. INFORMANT: MEMORIAL HOSPITAL — Address: CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation secondary to
420.0
DUE TO (b) Arteriosclerotic Heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Bronchial Asthma

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/5/62, 19..., to 1/6/62, 19..., that (I) (we) last saw the deceased alive on 1/6, 1962, and that death occured at 2:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: George M. Simons M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. GEORGE M. SIMONS

22d. ADDRESS: ALGONQUIN HOTEL - CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 9, 1962

23c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery

23d. LOCATION (City, town or county) (State): Hyndman, Pa. RD#1

24 FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Zeigler

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE JAN 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00032 **CERTIFICATE OF DEATH** 00032

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 11/16/1961
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Flintstone
d. STREET ADDRESS: R.F.D. #1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Virginia — Last: Dick
4. DATE OF DEATH: Month: January — Day: 26, — Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9/13/1884
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles Edward Ritter
14. MOTHER'S MAIDEN NAME: Laura Virginia Stottlemyer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Allegany County Infirmary records. Address: P.O.Box 599 Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchitis, degenerative, senile
DUE TO (b) Arteriosclerosis & Hypertension -
DUE TO (c) Left Hemiplegia - Marked cerebral deterioration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/16/61, 19....., to 1/26/62, 19....., that (I) (we) last saw the deceased alive on 1/26/62 19....., and that death occured at @ 10:20 A.M. M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [X] STAFF PHYS. [X]
22b. DATE SIGNED: 1/27/62
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN.29,1962
23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR: DATE JAN 31 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00033 00033

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale Md.
c. LENGTH OF STAY IN 1b: Life.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 550 'A' Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale Md.
d. STREET ADDRESS: 550 'A' Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Francis — Middle: J. — Last: Dressman
4. DATE OF DEATH: Month: Jan — Day: 9 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Apr. 14 1893
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocer
10b. KIND OF BUSINESS OR INDUSTRY: Self.
11. BIRTHPLACE (County & State, or foreign country): Cash Valley LaVale
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Dressman
14. MOTHER'S MAIDEN NAME: Mary Detterman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W W I
16. SOCIAL SECURITY NO.: 218-30-0708A
17. INFORMANT: Frederick Dressman — Address: La Vale Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
(b) Acute coronary occlusion — 1 hr.
DUE TO
(c) Arteriosclerotic & Rheumatic Heart Disease with cardiomegaly and chronic congestive failure — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
Diabetes Mellitus; Rheumatoid arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~XXXXXXXX~~) attended the deceased from March 30, 1960 to Jan. 9, 1962, that (I) (~~XX~~) last saw the deceased alive on January 9, 1962, and that death occured at 11:8 pm from the causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-12-62
22c. PHYSICIAN'S NAME (Type): Wyand F. Doerner, Jr., M.D.
22d. ADDRESS: 414 N. Mechanic Street, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/12/62
23c. NAME OF CEMETERY OR CREMATORY: St. Peter + Paul Cem
23d. LOCATION (City, town or county) (State): Cumberland, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. — ADDRESS: Cumberland Md.
25a. REC'D BY REGISTRAR — DATE: JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur E. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00034 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00034

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 66 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 306 Springdale St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 315 Springdale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert Middle: B. Last: Durbin
4. DATE OF DEATH: Month: Jan. Day: 25 Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1895
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Gaithersburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John H. Durbin
14. MOTHER'S MAIDEN NAME: Mary Norris
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): War I
16. SOCIAL SECURITY NO.: 705-05-77 48
17. INFORMANT: Carl Ray Durbin, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b) Coronary sclerosis — —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Jan. 25, 1962
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town, or county): R9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 28, 1962
22c. NAME OF CEMETERY OR CREMATORY: Mt. Tabor Cemetery
22d. LOCATION (City, town, or country) (State): Oldtown, Md.
23. FUNERAL DIRECTOR: James F. Scarpelli, ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JAN 29 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ASME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00035 00035

1 (M) 91 (I) 0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3/1/1960

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg
d. STREET ADDRESS: 80 Grant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

3. NAME OF DECEASED (Type or print): First: Hattie Middle: Last: Elliott
4. DATE OF DEATH: Month: January Day: 20, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/15/1876
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Johnstown, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George Henry Fisher
14. MOTHER'S MAIDEN NAME: Carry Gollipher
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia, Virus - Bilateral
DUE TO (b) Myocarditis, Chr. degenerative
DUE TO (c) Arteria Sclerosis & Cerebral deterioration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/1/1960 19....., to 1/20/62 19....., that (I) (we) last saw the deceased alive on 1/19/62 19....., and that death occurred at @ 6:15 A.M. M, from the causes and on the date stated above.

22a. SIGNATURE: R. Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 1/20/62
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-22-62
23c. NAME OF CEMETERY OR CREMATORY: M. E. Cemetery
23d. LOCATION (City, town or county) (State): Mt. Savage, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst
ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: JAN 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kime

VR A1S (4)
1SM 7/61

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00036 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00036

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Algonquin Hotel, Washington St.,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: Algonquin Hotel, Washington St.,
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First CHARLES Middle HARRISON Last FISHER

4. DATE OF DEATH: Month Jan. Day 1, Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: Nov. 18, 1888

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Brakeman

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy./

11. BIRTHPLACE (State or foreign country): Bedford Co. Penna.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas E. Fisher

14. MOTHER'S MAIDEN NAME: Minerva Stuby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No,

16. SOCIAL SECURITY NO. (If yes give were or dates of service): 705-09-4190

17. INFORMANT: Mrs. Cora Ronald — Address: 1323 Tyndal Ave., Pittsburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b) CORONARY SCELROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 1/1/62

EXAMINER'S NAME (Type): Benedict Skitarelic M.D.

Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/3/62

22c. NAME OF CEMETERY OR CREMATORY: Madley Cemetery

22d. LOCATION (City, town, or country) (State): Madley, Penna.

23. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: JAN 4 '62

24b. REGISTRAR'S SIGNATURE: Anthony S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00037 **CERTIFICATE OF DEATH** 00037

1 (M)

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: 6DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PA.
b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEDFORD
75X·3
d. STREET ADDRESS: 125½ EAST PITT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAULINE Middle: FRANCHI Last:

4. DATE OF DEATH: Month: JAN Day: 8, Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 12, 1888
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alemando MECONI
14. MOTHER'S MAIDEN NAME: Giovanna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.
(If yes give wer or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Lino J. Franchi 125½ E. Pitt St., Address: Bedford, Penna.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days
434-4
DUE TO (b) Myocardial fibrosis
DUE TO (c) Coronary arteriosclerosis
CARDIAC DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/2, 19 62 to 1/8, 19 62 that (I) (we) last saw the deceased alive on 1/8 19 62, and that death occured at 10:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/10/62
22c. PHYSICIAN'S NAME (Type): DR. JACOBSON
22d. ADDRESS: 50 PERSHING ST. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/12/62
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00038

CERTIFICATE OF DEATH

00038

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westernport
c. LENGTH OF STAY IN 1b: 71 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Westernport
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: May — Last: Green

4. DATE OF DEATH: Month: Jan. — Day: 17 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Mar. 20, 1890

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Garrett-MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dennis Grove

14. MOTHER'S MAIDEN NAME: Matilda Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO. (If yes give war or dates of service):

17. INFORMANT — Address: Frank Green-R.D. 1-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 5 Years
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 10, 1957 to Jan. 17, 1962 that (I) (we) last saw the deceased alive on Jan. 9 1962, and that death occured at 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson

22d. ADDRESS: Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/20/62

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION (City, town or county) (State): Westernport Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal — ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur E. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00039

CERTIFICATE OF DEATH

Reg. Dist. No. 00039

M

1. PLACE OF DEATH a. COUNTY ~~SOMERSET~~ Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, MD
c. LENGTH OF STAY IN 1b 3 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINORS HOSP, FROSTBURG, MD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD 11X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

61

3. NAME OF DECEASED (Type or print) First: FLORENCE Middle: ELIZEBETH Last: HANFT
4. DATE OF DEATH Month: JAN. Day: 12 Year: 1962

I

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH OCT. 27, 1897
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) ST PAUL SOMERSET Co, PA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LEWIS SMEARMAN
14. MOTHER'S MAIDEN NAME MARY MARGARET OPEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Adam Hanft Address Grantsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b) Hypertension Cardio-vascular disease — 3-4 yrs.
DUE TO (c) — 0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

1

21. I certify that I attended the deceased from 10-1, 1959, to 1-12, 1962, that I last saw the deceased alive on 1-12, 1962, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H. C. Diehl M.D. ADDRESS (Street, city or town, state) 39 W. Main St. DATE SIGNED 1/12/62

PHYSICIAN'S NAME (Type) H. C. DIEHL, M.D. Frostburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 1/15/62
22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE
22d. LOCATION (City, town, or county) (State) GRANTSVILLE, GARRETT Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE Don Newman ADDRESS Grantsville, Md.
24a. REC'D BY REGISTRAR DATE JAN 15 '62
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00040

CERTIFICATE OF DEATH

00040

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland Md.
d. STREET ADDRESS: 457 William St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Carleton Middle: W. Last: Hanks
4. DATE OF DEATH: Month: Jan Day: 10 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1898
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): ~~Pharmacist~~ Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (County & State, or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Ulysses Grant Hanks
14. MOTHER'S MAIDEN NAME: Minnie Dawson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or date of service): WW I
16. SOCIAL SECURITY NO.: 214-05-4077
17. INFORMANT: Mrs. Bessie Hanks Address: Cumb. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420 | DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Coronary Artery Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-10-1962 to 1-10-1962 ~~that~~ (I) ~~(we)~~ last saw the deceased alive on 1-10-1962, and that death occured at 12:35 P from the causes and on the date stated above.

22a. SIGNATURE: W. L. Williams M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-11-62
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/13/62
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Pk
23d. LOCATION (City, town or county) (State): Cumberland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE JAN 15 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00041 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00041

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 127 Columbia Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 127 Columbia Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie; Middle: ; Last: Hartsock
4. DATE OF DEATH: Month: January; Day: 22; Year: 19 62
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 28, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Bucy (Deceased)
14. MOTHER'S MAIDEN NAME: Stacia Shaw (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Marshall L. Hartsock — Address: 127 Columbia Street, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b) CALCIFIC AORTIC STENOSIS — OLD
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 2 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JANUARY 22, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): R9. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/25/62
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county): Cumberland (State): Maryland

23. FUNERAL DIRECTOR: Ruth E. Silcox
ADDRESS: 404 Decatur Street, Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: JAN 25 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00042 **CERTIFICATE OF DEATH** 00042

Item 3, Film G-307 2/15/62. cac.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 515 Riehl Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 515 Riehl Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): Also known as Mamie R. Helmstetter — First: Regina; Middle: Wilhelmina; Last: Helmstetter
4. DATE OF DEATH: Month: Jan.; Day: 18; Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 23 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Cash Valley, Rt 1, Cumberland Md
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George Helmstetter
14. MOTHER'S MAIDEN NAME: Sabina Rochrig
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Louis Madden — Address: 515 Riehl Ave. Comb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial aster arthritis & 723.0
DUE TO (b) anemia & osteoporosis of vertebra
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: years,

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1, 1961 to Jan. 18, 1962, that (I) (we) last saw the deceased alive on Jan. 4, 1962, and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schindler M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/20/62
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 22, 1962
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery
23d. LOCATION (City, town or county): Cumberland (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc. — ADDRESS: 117 Frederick St. Cumberland
25a. REC'D BY REGISTRAR DATE JAN 22 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00043 Reg. Dist. No. 00043

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MIDLOTHIAN
c. LENGTH OF STAY IN 1b: 4 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MIDLOTHIAN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS Middle R. Last HENDERSHOT
4. DATE OF DEATH: Month Jan Day 24 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 29, 1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MINER
10b. KIND OF BUSINESS OR INDUSTRY: COAL MINES
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JACOB HENDERSHOT
14. MOTHER'S MAIDEN NAME: WIGFIELD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: CHAS. HENDERSHOT, Address: ARTHURDALE, W. VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) Myocardial Insufficiency — 2 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W O McLane M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W O McLane MD asst
DATE SIGNED: Jan 24 1962 Frostburg Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-27-62
22c. NAME OF CEMETERY OR CREMATORY: OAKLAND CEMETERY
22d. LOCATION (City, town, or county) (State): OAKLAND, MD.
23. FUNERAL DIRECTOR'S SIGNATURE: H. K. Burst ADDRESS: FROSTBURG, MD.
24a. REC'D BY REGISTRAR DATE JAN 26 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation or removal.

VS. A1SME(5) 5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00044 **CERTIFICATE OF DEATH** 00044

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 explained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M 60 I 0 1

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MOUNT SAVAGE
d. STREET ADDRESS: ROUTE #1,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BABY — Middle BOY — Last HOLBROOK
4. DATE OF DEATH: Month JANUARY — Day 14, — Year 19 62.
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 13, 1962
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 23 / Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Allen Kendall
14. MOTHER'S MAIDEN NAME: FRANCES KAY HOLBROOK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day
776 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Jan 13, 1962 to Jan. 14, 1962, that (I) (we) last saw the deceased alive on Jan. 14 1962, and that death occured at 9:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. Pope Hodges M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/16/62
23c. NAME OF CEMETERY OR CREMATORY: Palo Alto Cemetery
23d. LOCATION (City, town or county) (State): Hyndman, Pa. RD#1

24. FUNERAL DIRECTOR'S SIGNATURE: Gilbert H. Leigler — ADDRESS: Hyndman, Pa.
25a. REC'D BY REGISTRAR DATE JAN 19 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

206016 10012

VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00045 00045

1 M 61 I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): FROSTBURG,
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Route 1, FROSTBURG,
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: C. Middle: MAE Last: HOUSE

4. DATE OF DEATH: Month: JANUARY Day: 22ND, Year: 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 6TH, 1885
9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOUSEWORK
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN HOUSE
14. MOTHER'S MAIDEN NAME: SARAH DENISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. **INFORMANT** Address: MISS JESSIE HOUSE, RT.1, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: indefinite
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1537

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): X
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): X
20c. TIME OF INJURY Hour a.m. p.m.: X Month, Day, Year: 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): X
20f. (City or town) (County) (State): X

21. **I certify** that (I) (this hospital) attended the deceased from Oct., 1961, to 1/22/62, 1962, that (I) (we) last saw the deceased alive on 1/22/62, 1962, and that death occured at 3 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Martin M. Rothstein M.D., M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/23/62
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN, M
22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-25-62
23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK
23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. R. Durant
ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE JAN 26 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00046 **CERTIFICATE OF DEATH** 00046

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTERNPORT
c. LENGTH OF STAY IN 1b: 15 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 84 MAIN STREET

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PIEDMONT 85X·3
d. STREET ADDRESS: 67 E. HAMPSHIRE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND — Middle C. — Last HUDSON
4. DATE OF DEATH: Month JANUARY — Day 2 — Year 1962
5. SEX: M
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 22, 1901
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INSURANCE
10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS
11. BIRTHPLACE (County & State, or foreign country): AMHERST CO. VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CARRINGTON O. HUDSON
14. MOTHER'S MAIDEN NAME: SAMANTHA GOOCH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 235-32-6913
17. INFORMANT: MRS. MILDRED HUDSON, PIEDMONT, W.VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 18 Months
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420 1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 5, 1960 to Jan 2, 1962 that (I) (we) last saw the deceased alive on Dec 29 1961, and that death occured at 3P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/3/62
22c. PHYSICIAN'S NAME (Type): DR. PAUL R. WILSON
22d. ADDRESS: ASHFIELD ST. PIEDMONT, W.VA.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/5/62
23c. NAME OF CEMETERY OR CREMATORY: PHILOS CEMETERY
23d. LOCATION (City, town or county) (State): WESTERNPORT ALLEGANY MD.
24 FUNERAL DIRECTOR'S SIGNATURE: W N Fredlock Jr — ADDRESS: PIEDMONT, W.VA.
25a. REC'D BY REGISTRAR: DATE JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Eunice S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00047 **CERTIFICATE OF DEATH** 00047

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Frostburg
d. STREET ADDRESS: Rt. #2, Box 110 (Zihlman)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle DONALD Last JAMISON

4. DATE OF DEATH: Month 1 Day 29 Year 19 62.

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-25-13
9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed (Ill)
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Deal, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jamison
14. MOTHER'S MAIDEN NAME: Susan Knepp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.No.2
16. SOCIAL SECURITY NO.: 214-07-3992
17. INFORMANT: Mrs. George Jones, Rt. #2, Box 110 (Zihlman) Address: Frostburg, Md. (Mother)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 26 hrs
DUE TO (b): advanced arteriosclerosis
DUE TO (c): Diabetes Mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 19 58 to Jan. 29 19 62 that (I) (we) last saw the deceased alive on 29 Jan 19 62 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: John B. Davis, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/29/62
22c. PHYSICIAN'S NAME (Type): John B. Davis, MD.
22d. ADDRESS: 2 Broadway Frostburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/1/62
23c. NAME OF CEMETERY OR CREMATORY: White Oak Cemetery
23d. LOCATION (City, town, or county) (State): White Oak, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montemuro
ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR A[illegible] PHYSICIAN: The law requires that the death certificate be executed within 24 hours after dea[illegible] Page 4 may be retained b[illegible]al or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f[illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shou[illegible] be filed wi[illegible] the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00048 **CERTIFICATE OF DEATH** 00048

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12/22/1961
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 60 Boone Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Catherine — Last: Johnson

4. DATE OF DEATH: Month: January — Day: 1, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/16/1886

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William Anthony Wadasz

14. MOTHER'S MAIDEN NAME: Catherine Moffatt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis chr. decompensating — INTERVAL BETWEEN ONSET AND DEATH
4-22-
DUE TO (b) Arteriosclerotic cardiovascular disease
DUE TO (c) ~~Coph~~ Cerebral Thrombosis Cerebrovascular deterioration

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/22/61, 19....., to 1-1-62, 19....., that (I) (we) last saw the deceased alive on 1-1-62 @ 8:00 A.M., 19....., and that death occured at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 1/1/1962

22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 4, 1962

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR: DATE JAN 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00049 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00049

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Between Res. & Cumb.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Enroute to Cumberland, Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cresaptown,
d. STREET ADDRESS: 5th Ave., at Main St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MATTIE Middle BELLE Last KNICK
4. DATE OF DEATH: Month Jan. Day 29, Year 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 23, 1892
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photo. Lab. Employee
10b. KIND OF BUSINESS OR INDUSTRY: Social Security
11. BIRTHPLACE (State or foreign country): Lexington, Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: (Unknown) Hicks
14. MOTHER'S MAIDEN NAME: (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No,
(If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: 216-14-1383
17. INFORMANT: Mr. Elbert Knick 5th Ave., @ Main St., Address Cresaptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b) CORONARY SCLEROSIS WITH THROMBOSIS — ------
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 1/29/62
EXAMINER'S NAME (Type): Benedict Skitarelic M.D.
Address (Street, city, town, or county): Rt. # 9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/1/62
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or country): Cumberland, (State) Md.

23. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE FEB 5 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Hawes

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00050 00050

M

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: W.VA. b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER 85x·3
d. STREET ADDRESS: RT#4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

62

3. NAME OF DECEASED (Type or print): First: Edna Middle: B. Last: Kooken
4. DATE OF DEATH Month: JAN Day: 3 Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-19-91
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Ours (D)
14. MOTHER'S MAIDEN NAME: CHRISTINA Snyder [redacted] (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Pt's Chart Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
585X
DUE TO (b) Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Possible acute cholecystitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-2, 1962 to ....., 19....., that (I) (we) last saw the deceased alive on 1-3, 1962, and that death occured at 9:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Earl R Paul M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-4-62
22c. PHYSICIAN'S NAME (Type): DR. EARL PAUL
22d. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/6/62
23c. NAME OF CEMETERY OR CREMATORY: Queen's Point
23d. LOCATION (City, town or county): Keyser (State): W.Va.

24 FUNERAL DIRECTOR'S SIGNATURE: C.E. Boal ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00051 **CERTIFICATE OF DEATH** 00051

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BARTON
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: FREDERICK — Middle: — Last: KYLE

4. DATE OF DEATH: Month: JANUARY — Day: 18 — Year: 1962 19

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 7-4-1905
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stewart
10b. KIND OF BUSINESS OR INDUSTRY: Firemen's Club
11. BIRTHPLACE (County & State, or foreign country): BARTON, MD.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: FRANK KYLE
14. MOTHER'S MAIDEN NAME: ANNA M. LEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-3750
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic coma — INTERVAL BETWEEN ONSET AND DEATH: 2 days
462.1
DUE TO (b) Hematemasis — 7 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Esophageal varices; gastritis; chronic pancreatitis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/13/62 19....., to 1/18/62 19....., that (I) (we) last saw the deceased alive on 1/18/62 19....., and that death occured at 9:12 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Samuel Jacobson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. SAMUEL JACOBSON
22d. ADDRESS: 50 Pershing Street, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/21/62
23c. NAME OF CEMETERY OR CREMATORY: Mt. View
23d. LOCATION (City, town or county) (State): Moscow Mills Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E. Boal — **ADDRESS**: Westernport, Md
25a. REC'D BY REGISTRAR DATE: JAN 23 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00052 Reg. Dist. No. 00052

M

62

1. PLACE OF DEATH a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural of Cumberland, Maryland
d. STREET ADDRESS: 5 Rose Lawn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Laurie Middle Ann Last Lehman
4. DATE OF DEATH: Month January Day 24 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 1, 1956
9. AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: David Calvert Lehman
14. MOTHER'S MAIDEN NAME: Jean Louise DeVore

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: David C. Lehman Address: 5 Rose Lawn Ave. La Vale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 15-20 Minutes
DUE TO (b) ASPIRATION OF STOMACH CONTENTS — 15-20 Minutes
DUE TO (c)

180 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): WILM'S TUMOR OF RIGHT KIDNEY
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JANUARY 24, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. R 9 Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/27/62
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 29 '62
24b. REGISTRAR'S SIGNATURE: Arthur J. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00053

CERTIFICATE OF DEATH

Reg. Dist. No. 00053

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 17 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

d. STREET ADDRESS: 10 Arch Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Nixon — Last: Linn

4. DATE OF DEATH: Month: January — Day: 22 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/88

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Retired

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): West Virginia-Keyser

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: David Linn

14. MOTHER'S MAIDEN NAME: Sarah Nixon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-2554

17. INFORMANT: Mrs. John Linn — Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b) Myocarditis, chr. degenerative
DUE TO (c) Arteriosclerosis, Senile

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 5, 1962, to Jan. 22, 1962, that I last saw the deceased alive on Jan. 22, 1962, and that death occurred at 2:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. B. Mathews M.D. — ADDRESS (Street, city or town, state): 49 Greene St., Cumberland, Md. — DATE SIGNED: 1-23-62

PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan.25,1962

22c. NAME OF CEMETERY OR CREMATORY: Union Cemetery

22d. LOCATION (City, town, or county) (State): Slanesville, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR: DATE JAN 29 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00054

CERTIFICATE OF DEATH

00054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

91

I

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2/1/1958
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 309 Decatur Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lulu; Middle: Grace; Last: Lowery

4. DATE OF DEATH: Month: January; Day: 27; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/26/1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Myersdale, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: David Franklin Geisbert

14. MOTHER'S MAIDEN NAME: Isabelle Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, degenerative, Senile
DUE TO (b) arteriosclerosis, degenerative
DUE TO (c) Cerebral Hemorrhage, left Hemiplegia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/1/1958, 19..., to 1/27/62, 19..., that (I) (we) last saw the deceased alive on 1/27/62, 19..., and that death occured at @ 2:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Lee B. Mathews M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 1/29/62

22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JAN. 30, 1962

23c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY

23d. LOCATION (City, town or county) (State): MEYERSDALE, PA.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: JAN 31 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00055 **CERTIFICATE OF DEATH** 00055

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): (Allegany) Cumberland (County)
c. LENGTH OF STAY IN 1b: 10/26/1960
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 533 Cumberland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene — Middle: Marie — Last: Martin

4. DATE OF DEATH: Month: January — Day: 1, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12/24/1893

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Marcellus Martin

14. MOTHER'S MAIDEN NAME: Elizabeth A. Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: P.O.Box 599 Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral apoplexy, Rt Hemiplegia
443 X
DUE TO (b) Cardiovascular Renal Disease & Hypertension
DUE TO (c) Arterio-Sclerosis (cerebral deliration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/26/60, 19..., to 1/1/62, 19..., that (I) (we) last saw the deceased alive on 1-1-62 19..., @ 5:30 A.M. and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: R. Bellis Lees M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 1/2/61

22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/3/62

23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem

23d. LOCATION (City, town or county) (State): Cumberland Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc — **ADDRESS**: Cumb. Md

25a. REC'D BY REGISTRAR DATE: JAN 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur J. Fran

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

Allegany

(Allegany) Cumberland 10\26\1960
(County)
Allegany County Infirmary

Irene Harris Martin

Female White 12\24\1973 69

Housekeeper

Marcellus Martin

Cumberland, Maryland U. S. A.

Elizabeth A. Kelley
P.O.Box 599 Cumberland, Md.
Allegany County Infirmary records.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00056 — 00056

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Moscow
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Moscow
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle — Last McCUTCHEON

4. DATE OF DEATH: Month 1/27/1962 — Day — Year 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/14/1878
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Barton, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: Sam McCutcheen
14. MOTHER'S MAIDEN NAME: Fannie Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. James McPartland, Lonaconing, MD. (Daughter) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
420.1
DUE TO (b) Arteriosclerotic Cardiovascular Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1961, to Jan 27, 1962, that (I) (we) last saw the deceased alive on Jan 23, 1962, and that death occured at 9 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-27-62
22c. PHYSICIAN'S NAME (Type): L.R. MILES, JR., M.D.
22d. ADDRESS: LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/29/1962
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City, town or county) (State): Moscow, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.
25a. REC'D BY REGISTRAR — DATE: JAN 30 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00057 **CERTIFICATE OF DEATH** 00057

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MIDLAND
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA Middle: S. Last: McFARLAND

4. DATE OF DEATH Month: JANUARY Day: 3RD Year: 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 4, 1883
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL STEVENSON
14. MOTHER'S MAIDEN NAME: MARTHA H. CLISE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MARGARET E. STEVENSON, Address 12 E. COLLEGE AVE, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 18 Days
DUE TO (b) Broncho Pneumonia — ?
DUE TO (c) — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 15 1961 to Jan 3 1962 that (I) (we) last saw the deceased alive on Jan 2 1962 and that death occurred at 4:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W O McLane M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 3 1962
22c. PHYSICIAN'S NAME (Type): W. O. McLANE
22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-6-1962
23c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY
23d. LOCATION (City, town or county) (State): ECKHART, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst — ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00058 Item 4 Film G305 1/11/62 1wk 00058

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 27 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 810 ASHLAND AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 810 ASHLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLA — Middle: McKINNEY — Last:

4. DATE OF DEATH: Month: January — Day: 2 — Year: 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: OCT.9,1888
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: HENRY SOLOMAN
14. MOTHER'S MAIDEN NAME: SUSAN KING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: WALTER A. McKINNEY — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 12 mos
DUE TO (b)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 10-22-61 19___, to 1-2-62, 19___, that (I) (we) last saw the deceased alive on 1-2-62 19___, and that death occurred at 9p M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1-4-62
22c. PHYSICIAN'S NAME (Type): Ralph W. Ballin, M.D.
22d. ADDRESS: 62 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN.61962
23c. NAME OF CEMETERY OR CREMATORY: FOREST HILLS CEMETERY
23d. LOCATION (City, town, or county) (State): PIQUA, OHIO
24. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR — DATE: JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Chelsea L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00059 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00059

Item 11 Film G306 1/31/62 jwk

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNSYLVANIA — COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYNDMAN 75X3
d. STREET ADDRESS: CHURCH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE Middle ELIZABETH Last MILLER
4. DATE OF DEATH: Month JANUARY Day 22 Year 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-5-1875
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ~~USA~~ Penna.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: CHARLES SHAFFER
14. MOTHER'S MAIDEN NAME: EVELINE WELCH
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MEMORIAL HOSPITAL — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO
(b) CEREBRAL CONTUSIONS — 3 Days
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): FRACTURED RIBS, LEFT

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): AUTOMOBILE ACCIDENT
20c. TIME OF INJURY Month, Day, Year — Hour 5:00 p.m. Jan. 19 1962
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Near Hyndman (County) Bedford (State) Pa.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 22, 1962
Address (Street, city, town, or county): R9 Cumberland, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/24/62
22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
22d. LOCATION (City, town, or county) (State): Hyndman, Bedford Co. Pa.
23. FUNERAL DIRECTOR: Harvey H. Zeigler, ADDRESS: Hyndman, Penna.
24a. REC'D BY REGISTRAR DATE JAN 26 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00060

CERTIFICATE OF DEATH

Reg. Dist. No. 00060

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 2yrs. 3mos. 26days.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg

d. STREET ADDRESS: 101 Maple Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucille Middle: C. Last: Naff

4. DATE OF DEATH Month: January Day: 7 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 4/14/83

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rhodes Smith

14. MOTHER'S MAIDEN NAME: Belle Leach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dr. Lucille Clay, 101 Maple St., (Dght) Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, degenerative, senile — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Chr. Brain Syndrome c̄ Psychosis

DUE TO (c) Reaction - 17:11

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1961, to Jan. 7, 1962, that I last saw the deceased alive on Jan. 6, 1962, and that death occurred at 12:10 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Mathews M.D. ADDRESS (Street, city or town, state): 49 Greene Street, Cumberland, Md. DATE SIGNED: 1/8/62

PHYSICIAN'S NAME (Type): L. B. Mathews, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/9/62

22c. NAME OF CEMETERY OR CREMATORY: Winchester Cemetery

22d. LOCATION (City, town, or county) (State): Winchester, Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Moulton ADDRESS: Hafer Funeral Home 25 E. Main, Frostburg, Md.

24a. REC'D BY REGISTRAR DATE JAN 11 '62

24b. REGISTRAR'S SIGNATURE: Orline L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: ...er this certificate has been signed by the attending physician and completely filled in by the funeral director, ... page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sh... ...e filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 3&13 [illegible] 2/6/62 iwk

00061 **CERTIFICATE OF DEATH** 00061

Item 7 Film G 206 2/6/62 iwk

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 19 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 02 XXXXXXXXXXXX CUMBERLAND
d. STREET ADDRESS: 11 E FIRST STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ XXX

3. NAME OF DECEASED (Type or print): First DAVID — Middle C — Last O'Connor O'CONNER

4. DATE OF DEATH: Month 1 — Day 30 — Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ unknown

8. DATE OF BIRTH: 12/17/89

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Railroad Railroad

11. BIRTHPLACE (County & State, or foreign country): Arlington Neb.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David C. ~~O'Connor~~ O'Connor

14. MOTHER'S MAIDEN NAME: Anna E. Shaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) myocarditis & Decompensation — 6 wks
DUE TO (c) Arteriosclerosis — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1962 to Jan 30, 1962, that (I) (we) last saw the deceased alive on Jan 30 1962, and that death occured at 8:40 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Clark R. Durrett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/31/62

22c. PHYSICIAN'S NAME (Type): DR DURRETT

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-2-62

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE FEB 6 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
1SM 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00062 **CERTIFICATE OF DEATH** 00062

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 23 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 1 Cumberland,
d. STREET ADDRESS: Upper Homewood Add.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle THOMAS Last PLUMMER
4. DATE OF DEATH: Month 1 Day 22 Year 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/9/95
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trackman,
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.
11. BIRTHPLACE (County & State, or foreign country): Rawlings, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Francis M. Plummer
14. MOTHER'S MAIDEN NAME: Eugenia Ullum
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes, (If yes give war or dates of service): W.W. # 1
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Catherine M. Plummer Address Rt. # 1 Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure (intractable) — INTERVAL BETWEEN ONSET AND DEATH: 3½ months

DUE TO (b) Old Large Myocardial Infarction of left ventricle — ?

DUE TO (c) Coronary Arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Absence of leftkidney; pyelonephritis of right kidney;cardiac cirrhosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November 29, 1961, to January 22, 1962 that (I) (we) last saw the deceased alive on January 21, 1962, and that death occured at 12:30 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Wyand F. Doerner Jr M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1-23-62
22c. PHYSICIAN'S NAME (Type): DR. DOERNER, Wyand F. Jr.
22d. ADDRESS: 414 N. Mechanic St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/25/62
23c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE JAN 25 '62
25b. REGISTRAR'S SIGNATURE: William S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00063 **CERTIFICATE OF DEATH** 00063

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BARTON
c. LENGTH OF STAY IN 1b: 42 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BARTON
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLIVER Middle T. Last PORTER

4. DATE OF DEATH: Month JANUARY Day 22ND, Year 19 62

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEB. 4th, 1888
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINE OPERATOR
10b. KIND OF BUSINESS OR INDUSTRY: COAL MINING
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM PORTER
14. MOTHER'S MAIDEN NAME: MARGARET LANCASTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-32-3023
17. INFORMANT: Miss Mildred Porter, Barton, Md. Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs ?
DUE TO (b) Arteriosclerosis
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/1/62, 19..., to 1/22/62, 19..., that (I) (we) last saw the deceased alive on ...19..., and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R W Reeves MD M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): RAYMOND W. REEVES, "
22d. ADDRESS: WESTERNPORT, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-24-62
23c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY
23d. LOCATION (City, town or county): ECKHART, (State) MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst
ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE JAN 26 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00064

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1/21/61
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 727 Fayette Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: Elizabeth — Last: Rafter

4. DATE OF DEATH: Month: January — Day: 22, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/28/1878

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Keyser, West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Davis

14. MOTHER'S MAIDEN NAME: Mary Frances Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: P.O.Box 599 — Address: Cumberland, Md.
Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocarditis, degenerative, Senile
DUE TO (b) arteriosclerosis & Hypertension
DUE TO (c) Cerebral Hemorrhage, left Hemiplegia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/21/61 19....., to 1/22/62, 19....., that (I) (we) last saw the deceased alive on 1/22/62 19....., and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒

22b. DATE SIGNED: 1/23/62

22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JAN.25,1962

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR — DATE: JAN 26 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A1S (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00065 00065

1 (M) 99 (I)

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 FROSTBURG
d. STREET ADDRESS: 59 TARN TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle A. Last RALSTON
4. DATE OF DEATH: Month JANUARY Day 1, Year 1962
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JAN. 16, 1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAMES M. CONDON
14. MOTHER'S MAIDEN NAME: ELLEN RAFFERTY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212-18-1567B
17. INFORMANT: MRS. VIRGINIA KIGHT, Address 59 TARN TERRACE, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Hypertension
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

INTERVAL BETWEEN ONSET AND DEATH: 2 hours; several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1960, 19, to Jan 1, 1962 that (I) (we) last saw the deceased alive on Jan 1 1962 and that death occured at 8:42 AM, from the causes and on the date stated above.

22a. SIGNATURE: W O McLane M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 3 1962
22c. PHYSICIAN'S NAME (Type): W. O. McLANE, M. D.
22d. ADDRESS: E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 4 '62
23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY
23d. LOCATION (City, town or county) (State): FROSTBURG, MD.
24. FUNERAL DIRECTOR'S SIGNATURE: J. R. Durst
ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

TO HOSPITAL [illegible] TTENDING PHYSICIAN: The law requires that the death certificate be executed [illegible] hours after death. Page 4 m[illegible] be retained by the hospital or attending physician.

TO FUNERAL D[illegible]CTOR: After this certificate has been signed by the attending physician and completely [illegible] the funeral director, page 3 s[illegible]uld be detached for use as the burial-transit permit. Then please remove carbon paper[illegible] [illegible]uld be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, w[illegible]

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00066 **CERTIFICATE OF DEATH** 00066

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg, Maryland
d. STREET ADDRESS: 82 Beall Street, Extended
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Lashorn — Last: Redman

4. DATE OF DEATH: Month: January — Day: 28 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Black
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/24/1862
9. AGE (In years last birthday): 99 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Petersburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Redman
14. MOTHER'S MAIDEN NAME: Hannah Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Rosia Kelly, Frostburg, Maryland — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): X
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): X
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 X
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ X
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): X
20f. (City or town) (County) (State): X

21. **I certify** that (I) (this hospital) attended the deceased from June 6, 1961 to 1/28, 1962, that (I) (we) last saw the deceased alive on 1/28 1962, and that death occured at 2:30 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Martin Rothstein MD M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/29/62
22c. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN MD
22d. ADDRESS: 48 BROADWAY FROSTBURG MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/31/62
23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
23d. LOCATION (City, town or county) (State): Frostburg Md

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 31 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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FOR STATE HEALTH DEPT.

TO DEPUTY M[illegible] EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral di[illegible]. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00067 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00067

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cumberland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Pennsylvania b. COUNTY: Bedford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyndman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X·3

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3. NAME OF DECEASED (Type or print): First WILLIAM Middle B Last RITCHEY
4. DATE OF DEATH: Month January Day 1 Year 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 20, 1917
9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese
10b. KIND OF BUSINESS OR INDUSTRY: Textiles
11. BIRTHPLACE (State or foreign country): Hyndman, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Blair Ritchey
14. MOTHER'S MAIDEN NAME: Laura Kennedy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 208-03-7245
17. INFORMANT: Mrs. William Ritchey Address: Hyndman, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GUNSHOT WOUND OF ABDOMEN — INTERVAL BETWEEN ONSET AND DEATH: 8 Days
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

919.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) ACCIDENTLY SHOT WHILE HUNTING
20c. TIME OF INJURY Hour 11:45 a.m. Month, Day, Year Dec. 26 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Forest
20f. (City or town) RD#1 (County) Hyndman, (State) Bedford Co Pa.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: January 1, 1962
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
Address (Street, city, town, or county): R.9 Cumberland, MdD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/4/62
22c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
22d. LOCATION (City, town, or country) Hyndman, (State) Bedford Co Penna.

23. FUNERAL DIRECTOR: Harvey H. Zeigler, Hyndman, Pennsylvania
24a. REC'D BY REGISTRAR: DATE JAN 3 '62
24b. REGISTRAR'S SIGNATURE: Carlton S. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00068 00068

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 701 PIEDMONT AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA — Middle F. — Last ROEMMELMEYER

4. DATE OF DEATH: Month JANUARY — Day 1 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: SEPTEMBER 25, 1886

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ~~HARRY~~ THEODORE SCHIMMEL

14. MOTHER'S MAIDEN NAME: JULIA A. UCH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
154X
DUE TO (b): Carcinoma rectosigmoid area with carcinomatosis — 4 months.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertensive and arteriosclerotic cardiovascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19 to 1 Jan., 1962 that (I) (we) last saw the deceased alive on 1 Jan. 1962, and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3 Jan. 62

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/5/62

23c. NAME OF CEMETERY OR CREMATORY: Willow View Cemetery

23d. LOCATION (City, town or county) (State): Carbondale Pa

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer Cumberland Md

25a. RECD BY REGISTRAR — DATE: JAN 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00069 **CERTIFICATE OF DEATH** 00069

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 724 MARYLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH Middle Last ROGERS

4. DATE OF DEATH: Month 1 Day 8 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-30-08

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Raliroad

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA Monongah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: BRUCE ROGERS

14. MOTHER'S MAIDEN NAME: Ada Gandy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 234-09-8175

17. INFORMANT: PT'S CHART Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, acute, anteroseptal — INTERVAL BETWEEN ONSET AND DEATH: 17 days
4-20.0
DUE TO (b) Arteriosclerotic Heart Disease — 17 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 23, 1961, to Jan 8, 1962 that (I) (we) last saw the deceased alive on Jan 8 1962, and that death occured at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE S. G. Weisman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 1/9/62

22c. PHYSICIAN'S NAME (Type): S.G. WEISMAN, M.D.

22d. ADDRESS: 59 GREENE ST.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: I-12-62

23c. NAME OF CEMETERY OR CREMATORY: Masonic Lodge Cemetery

23d. LOCATION (City, town or county) (State): Shinnston, W.Va.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JAN 12 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 7/61

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00070 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00070

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 6yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6 Eculid Place

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland 02
d. STREET ADDRESS: 6 Eculid Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Holt — Middle: — Last: Scott
4. DATE OF DEATH: Month: January — Day: II — Year: 19 62
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 26, 1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Macaroni Factory
11. BIRTHPLACE (State or foreign country): Rowlesburg, W.Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Egnitious Scott
14. MOTHER'S MAIDEN NAME: Zuella De Witt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 067-10-6189
17. INFORMANT: Mrs. Gladys Scott, Address: Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH: sudden

9767

DUE TO (b) (Self Inflicted)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, MD.
Address (Street, city, town, or county): Allegany
DATE SIGNED: Cumberland, Md. Jan 13, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 14, 1962
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or country) (State): Cumberland, Md.
23. FUNERAL DIRECTOR: James F. Scarpelli, ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: JAN 16 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY M. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00071 00071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 has been signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY COUNTY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
c. LENGTH OF STAY IN 1b: 12 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL WARWICK. *MEMORIAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND, MARYLAND
d. STREET ADDRESS: 231 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERNICE Middle E. Last SHANER
4. DATE OF DEATH: Month 1-21- Day Year 19 62
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-12-1907
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Printing Co.
11. BIRTHPLACE (County & State, or foreign country): ROCKWOOD, PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM STERNER
14. MOTHER'S MAIDEN NAME: GRACE MYERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 215-20-6024
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Lungs (metastatic)
DUE TO (b) Carcinoma Breast Rt.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1960 to Jan, 1961, that (I) (we) last saw the deceased alive on 21 Jan 1961, and that death occured at 8:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Fuller B Whitworth M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. F.B.WHITWORTH
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan.23,1962
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county) (State): Cumberland,Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE JAN 24 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VR A1S (4) 15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00072 00072

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: BOWLING AVENUE, BOWLING GREEN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KAREN Middle JANINE Last SHIPLEY
4. DATE OF DEATH: Month JANUARY Day 9 Year 1962
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 6, 1962
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months Days 3 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: LEO H. SHIPLEY
14. MOTHER'S MAIDEN NAME: IRENE A. ANDERSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
776X
INTERVAL BETWEEN ONSET AND DEATH: 3 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan-6, 1962 to Jan-9, 1962, that (I) (we) last saw the deceased alive on Jan-9, 1962, and that death occured at 11:47 P.M. from the causes and on the date stated above.

22a. SIGNATURE: H W Eliason M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jany-10 62
22c. PHYSICIAN'S NAME (Type): HAROLD W. ELIASON DR. ~~XXXXXXXXXXXXXXXX~~
22d. ADDRESS: 203 GREENE ST., ~~XXXXXXXXXXXXXXXX~~, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/11/62
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE JAN 12 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4) 15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00073 **CERTIFICATE OF DEATH** 00073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

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1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
d. STREET ADDRESS: 311½ RACE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY Middle: BOY Last: SHIPWAY
4. DATE OF DEATH: Month: JANUARY Day: 16 Year: 1962
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JANUARY 12, 1962
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 4 IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): MARYLAND CUMBERLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: THOMAS T. SHIPWAY
14. MOTHER'S MAIDEN NAME: CAROL JANE METZ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity 4 days
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-12, 1962 to 1-16, 1962, that (I) (we) last saw the deceased alive on 1-16, 1962, and that death occured at 2:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W P Hodges M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): DR. HODGES.
22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 17, 1962
23c. NAME OF CEMETERY OR CREMATORY: Fairview M.E.Cemetery
23d. LOCATION (City, town or county) (State): near Baltimore Pike Cumberland

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli, Cumberland, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: JAN 18 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

20 60 191 010

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

BABY BOY

MALE WHITE

THOMAS T. SHIRMAY

CAROL JANE METZ

MEMORIAL HOSPITAL - CUMBERLAND, MD.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00074 **CERTIFICATE OF DEATH** 00074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 8Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg X
d. STREET ADDRESS: Rt. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ETHEL Middle: A. Last: SHOEMAKE
4. DATE OF DEATH: Month: 1 Day: 1 Year: 1962
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/27/1904
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Zihlman
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Martin Lockard
14. MOTHER'S MAIDEN NAME: Mary Lee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. George Shoemake, Rt. #2, Frostburg, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial insufficiency. — 1 yr.
DUE TO (b): Hypertension cardiovascular disease. — 4 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4437
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan 1, 1962 to Jan 1, 1962, that (I) (~~we~~) last saw the deceased alive on Jan 1 1962, and that death occured at 8:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Alvin J. Walters M.D.
22b. DATE SIGNED
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Alvin J. Walters M.D.
22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/4/62
23c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery,
23d. LOCATION (City, town or county): Eckhart (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montereagh
ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.
25a. REC'D BY REGISTRAR DATE JAN 9 '62
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00075 **CERTIFICATE OF DEATH** 00075

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 42 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 122 HANOVER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: A. Last: SHUCK

4. DATE OF DEATH: Month: JAN. Day: 30, Year: 19 62

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 3-27-1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Rubber worker
10b. KIND OF BUSINESS OR INDUSTRY: Goodyear Rubber Co.
11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JOSIAH SHUCK
14. MOTHER'S MAIDEN NAME: Maria LOUISA WHITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 274-01-0373
17. INFORMANT: MEMORIAL HOSPITAL- CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 days
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/19/61 7:48 P.M. 19..., to 1/30/62 19..., that (I) (we) last saw the deceased alive on 1/30/62 19..., and that death occured at ...M. from the causes and on the date stated above.

22a. SIGNATURE: O. Williams M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/31/62
22c. PHYSICIAN'S NAME (Type): DR. RICHARD J. WILLIAMS
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 2. 1962
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer
ADDRESS: 230 Baltimore Ave. Cumb. Md.
25a. REC'D BY REGISTRAR DATE FEB 6 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] hours after death. Page 4 [illegible] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages [illegible] and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00076 **CERTIFICATE OF DEATH** 00076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Luke
c. LENGTH OF STAY IN Ib: 44 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 413 Pratt St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Luke
d. STREET ADDRESS: 413 Pratt
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie Middle: Mae Last: Sively

4. DATE OF DEATH: Month: Jan. Day: 30 Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1887
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cooks helper
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (County & State, or foreign country): Rockbridge Ct. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Kirkpatrick
14. MOTHER'S MAIDEN NAME: Nancy J. Kelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 232-54-4573
17. INFORMANT: Milton Sively-Luke, Md. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of the large bowel — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fractured hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 30, 1962 to Jan 30, 1962 that (I) (we) last saw the deceased alive on 1-30 1962 and that death occured at 3:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE: William W. Lesh M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-1-62
22c. PHYSICIAN'S NAME (Type): Wm. W. Lesh
22d. ADDRESS: Westernport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/1/62
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City, town or county): Westernport (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal
ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00077 **CERTIFICATE OF DEATH** 00077

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS: Jackson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ISABELLE Middle: Last: STEINBAUGH

4. DATE OF DEATH Month: 1 Day: 10 Year: 1962 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 8/21/1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City or town, state, or foreign country): Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Johnston

14. MOTHER'S MAIDEN NAME: Sarah Spiker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mr. Leroy Coleman, Lonaconing, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

420.1

DUE TO (b): Arteriosclerotic CV disease Class III — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb., 1956 to Jan 10, 1962, that (I) (we) last saw the deceased alive on Jan 10 1962, and that death occured at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. R. Miles Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/11/62

22c. PHYSICIAN'S NAME (Type): L. R. MILES, JR., M.D.

22d. ADDRESS: LONACONING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/12/1962

23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

23d. LOCATION (City, town or county) (State): Moscow, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE: JAN 15 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Travers

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00078 00078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KEYSER 85x3
d. STREET ADDRESS: 151 S. MINERAL ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY — Middle: BOY — Last: STICKLEY
4. DATE OF DEATH: Month: JANUARY — Day: 9, — Year: 19 62
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-8-1962
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: CARL D. STICKLEY
14. MOTHER'S MAIDEN NAME: MARGARET L. KISER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fibrous Pleurisy — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Pulmonary fibrosis — 1 day
DUE TO (c): Cerebral anoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

762.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/8/, 19 62 to 1/9/, 19 62, that (I) (we) last saw the deceased alive on 1/9/62, 19, and that death occured at 10:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W Royce Hodges M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-10-62
22c. PHYSICIAN'S NAME (Type): DR. W. ROYCE HODGES
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-11-62
23c. NAME OF CEMETERY OR CREMATORY: Potomac Valley Memorial Gardens
23d. LOCATION (City, town or county) (State): Keyser, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas L. Smith — ADDRESS: Keyser, W.Va.
25a. REC'D BY REGISTRAR: DATE JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hurst

VR A1S (4) 15M 7/61

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00079 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00079

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): D. O. A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 227 So. Mechanic St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: PAUL; Middle: CHESTER; Last: STICKLEY

4. DATE OF DEATH: Month: Jan.; Day: 12; Year: 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 22, 1908
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supplyman
10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rwy.
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John M. Stickley
14. MOTHER'S MAIDEN NAME: Bertha Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes, (If yes give war or dates of service): W.W. # 2
16. SOCIAL SECURITY NO.: 705-09-9372
17. INFORMANT: Mrs. Mildred C. Stickley — Address: Cumb. Md. 227 So. Mechani

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420-1
DUE TO (b) CORONARY SCLEROSIS — ----
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JANUARY 12, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): R.D.9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/15/62
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: JAN 16 '62
24b. REGISTRAR'S SIGNATURE: Gordon L. Hanna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00080 **CERTIFICATE OF DEATH** 00080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 710 Elm St.,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 619 Leiper St.,
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Riley Middle: Everhart Last: Twigg
4. DATE OF DEATH: Month: Jan. Day: 28, Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 16, 1878
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (County & State, or foreign country): Green Ridge, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Levin Twigg
14. MOTHER'S MAIDEN NAME: Orlena Nicely
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, (If yes give war or dates of service): -------
16. SOCIAL SECURITY NO.: 232-10-9188
17. INFORMANT: Mrs. Markwood Chaney Address: 710 Elm St., Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO (b) Arteriosclerosis — 5 yrs
DUE TO (c) Gangrene Lower Extremities — 3 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 24, 1962 to Jan. 28, 1962 that (I) (we) last saw the deceased alive on Jan 24 1962, and that death occured at 5:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1/29/62
22c. PHYSICIAN'S NAME (Type): Clay E. Durrett M.D.
22d. ADDRESS: 236 Va. Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/31/62
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 31 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Frank

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00081 **CERTIFICATE OF DEATH** 00081

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MC COOLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: — Last: VINEY
4. DATE OF DEATH: Month: JANUARY — Day: 8 — Year: 1962

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: SEPT. 8, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tipple Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (County & State, or foreign country): LUKE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES VINEY
14. MOTHER'S MAIDEN NAME: SARAH CROWTHERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 236-03-3892
17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Congestive Heart Failure — 2 years
422.1
DUE TO
(b) Arteriosclerotic cardio-vascular disease — 5 years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-2, 1962 to 1-8, 1962, that (I) (we) last saw the deceased alive on 1-8 1962, and that death occurred 9:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-8-62
22c. PHYSICIAN'S NAME (Type): RALPH W. BALLIN
22d. ADDRESS: 62 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11 Jan 62
23c. NAME OF CEMETERY OR CREMATORY: Potomac Valley Memorial
23d. LOCATION (City, town or county) (State): Keyser, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Allen M. Rotruck
ADDRESS: Keyser, W. Va.
25a. REC'D BY REGISTRAR DATE: JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00082 00082

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 30 N. Lee St.,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 30 N. Lee St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eleanor; Middle: ; Last: Weisenmiller
4. DATE OF DEATH: Month: Jan. Day: 14, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 21, 1867
9. AGE (In years last birthday): 94 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Michael Yupa
14. MOTHER'S MAIDEN NAME: Johanna ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Helene M. Jones Address: 30 N. Lee St., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO
(b) CORONARY SCLEROSIS — ----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JANUARY 14, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): R 9 CUMBERLAND, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/17/62
22c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.
22d. LOCATION (City, town, or country) (State): Cumberland, Maryland
23. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE JAN 17 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00083 00083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 [illegible] retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 334 BALTIMORE AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SALLYE; Middle; Last WELSH

4. DATE OF DEATH: Month JANUARY; Day 7; Year 19 62

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 2, 1878
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LLOYD BUCY
14. MOTHER'S MAIDEN NAME: JENNIE WOLFORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Bacteremia

490X

DUE TO (b) Lobar Pneumonia — 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 6, 1961, to JAN, 1962, that (I) ~~(we)~~ last saw the deceased alive on JAN 1962, and that death occured at 7:45 AM from the causes and on the date stated above.

22a. SIGNATURE: L Michael Glick M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): L. MICHAEL GLICK
22d. ADDRESS: 126 N. SMALLWOOD CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 9, 1962
23c. NAME OF CEMETERY OR CREMATORY: BALD HILL CEMETERY
23d. LOCATION (City, town or county) (State): ROUTE 3, BEDFORD, PA.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.
25a. REC'D BY REGISTRAR DATE JAN 11 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00084 **CERTIFICATE OF DEATH** 00084

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 12/6/1961
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 430 Pine Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Conrad — Middle: — Last: Wenteroth
4. DATE OF DEATH: Month: January — Day: 6, — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/21/1877
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Potomac Edison Co.
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Louis Wenteroth
14. MOTHER'S MAIDEN NAME: Annie Heavener
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 217-10-9050
17. INFORMANT: P.O.Box 599 — Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis, chronic degenerative
DUE TO (b): Arterio-Sclerosis cerebral deterioration
DUE TO (c): Cholecystitis, chr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/6/61, 19..., to 1/6/62, 19..., that (I) (we) last saw the deceased alive on 1/5/62 @ 6:00 A.M., 19..., and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22b. DATE SIGNED: 1/6/1962
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/8/62
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City, town or county) (State): Cumberland Md
24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland Md
25a. REC'D BY REGISTRAR DATE: JAN 12 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00085 00085

1 M 60 I 0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 HR. 12 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 1 OAKWOOD AVE., ROBERTS PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANGELA — Middle Agnes — Last WIGFIELD
4. DATE OF DEATH: Month JANUARY — Day 25 — Year 19 62
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 1, 1914
9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HWFE. & REG. NURSE
10b. KIND OF BUSINESS OR INDUSTRY: Own home, Hosp.
11. BIRTHPLACE (County & State, or foreign country): ECKHART, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: SAMUEL ROBINSON
14. MOTHER'S MAIDEN NAME: ANNA Byrnes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, (If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Several hours.
DUE TO (b):
331 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertensive Arteriosclerotic vascular dis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-5-54 to 1-25-62 that (I) (~~we~~) last saw the deceased alive on 1-25-62 and that death occured at 2:12 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-25-62
22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS
22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/27/62
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.
23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George — ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR — DATE JAN 29 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A1S (4) 15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00086 **CERTIFICATE OF DEATH** 00086

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1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (Name of hospital, Street and number): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
d. STREET ADDRESS: 36 ROBERTS STREET
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

60 1

3. NAME OF DECEASED (Type or print): First: MAUDE Middle: Lavena Last: WILLIAMS
4. DATE OF DEATH: Month: JANUARY Day: 21 Year: 1962
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: MARCH 4, 1889
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Columbia Furnace, Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: NELSON FADLEY
14. MOTHER'S MAIDEN NAME: ANNIE WOODROW
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND Address:

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO (b) —
DUE TO (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Cumberland (County) Allegany (State) Md.

21. I certify that (I) (this hospital) attended the deceased from 12/11/62, 19..., to 1/21/62, 19..., that (I) (we) last saw the deceased alive on 1/21/62, 19..., and that death occured at 9:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R J Williams M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1/22/62
22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22d. ADDRESS: 122 SOUTH CENTRE ST. CUMBERLAND, MD.

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/24/62
23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery,
23d. LOCATION (City, town or county) (State): Fort Ashby, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JAN 25 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [redacted] hours after death. Page 4 [redacted] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00087 **CERTIFICATE OF DEATH** 00087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 [illegible] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

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1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4/9/1959
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 430 Columbia Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: E. Last: Wilson
4. DATE OF DEATH: Month: January Day: 12, Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/8/1884
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Anthony Shriver
14. MOTHER'S MAIDEN NAME: Catherine O'Shea
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: P.O.Box 599 Address: Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocarditis, chr. degenerative
584X
DUE TO (b): Arteriosclerosis a Cerebral deterioration
DUE TO (c): Cholelithiasis - Senile Psychosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/9/59, 19..., to 1/12/62, 19..., that (I) (we) last saw the deceased alive on 1/12/62, 19..., and that death occured at @ 8:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-13-62
22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/15/62
23c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul Cem
23d. LOCATION (City, town or county) (State): Cumberland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. ADDRESS: Cumb. Md.
25a. REC'D BY REGISTRAR DATE: JAN 16 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00088 00088

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 302 So. Allegany St.,

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland,
d. STREET ADDRESS: 302 So. Allegany St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN Middle: FERMAN Last: WINTERS
4. DATE OF DEATH: Month: Jan. Day: 3, Year: 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 23, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Plumbing Frm.
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George W. Winters
14. MOTHER'S MAIDEN NAME: Gertrude Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes, (If yes give war or dates of service): W. W. # 1
16. SOCIAL SECURITY NO.: 217-10-5192
17. INFORMANT: Miss, Margaret L. Winters Address: 302 S. Allegany Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis -
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1958 19..., to 1/3 ..., 19 62 that (I) (we) last saw the deceased alive on 1-3- 19 62 and that death occured at 10:45P M, from the causes and on the date stated above.

22a. SIGNATURE: L. B. Mathews M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/4/62
22c. PHYSICIAN'S NAME (Type): L. B. Mathews M.D.
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/6/62
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE JAN 8 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00089 **CERTIFICATE OF DEATH** 00089

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with [redacted] hours after death. Page 4 [redacted] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 54 McCULLOH STREET

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 54 McCULLOH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle S. Last YATES
4. DATE OF DEATH: Month JANUARY Day 31 st, Year 19 62
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 7th, 1889
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOUSEWORK
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: HENRY O. STEVENS
14. MOTHER'S MAIDEN NAME: SARAH DAVIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. GLADYS KLOSTERMAN, Address GRAHAMTOWN, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Dilatation — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Hypertension — several years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

434X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1959 19 to Jan 31 1962 that (I) (we) last saw the deceased alive on Jan 15 1962 and that death occured at 10:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. O. McLane M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb 2/1962
22c. PHYSICIAN'S NAME (Type): W. O. McLANE, "
22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-3-62
23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK
23d. LOCATION (City, town or county): FROSTBURG, (State) MD.

24. FUNERAL DIRECTOR'S SIGNATURE: L. R. Durst
ADDRESS: FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

VR A1S (4) 15M 7/61